		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040865

Facility Name: DIXON HEALTH CARE CENTER

Address: 111 NORTH COURT (Number) DIXON (City) 61021 (Zip Code)

County: LEE

Telephone Number: (815) 288-1477 **Fax #** (815) 288-9512

IDPA ID Number: 75-2080781

Date of Initial License for Current Owners: 09/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cathy Simeoni **Telephone Number:** (714) 596-7713 Ext. 12

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Linda Holtzscheiter

(Title) Reimbursement Manager

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Cathy Simeoni, Manager - Healthcare Consulting

(Firm Name & Address) Kellogg & Andelson, Accountancy Corporation
16162 Beach Blvd. #308, Huntington Beach, CA 92647

(Telephone) (714)596-7713 Fax # (714)596-7721

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,744	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,254	655	1,444	4,353	8
9	SNF/PED					9
10	ICF	18,935	6,961	352	26,248	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,189	7,616	1,796	30,601	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.01%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/15/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1,439

Medicare Intermediary AdminaStar Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	128,906	9,904	5,867	144,677		144,677		144,677			1
2	Food Purchase		138,487		138,487		138,487		138,487			2
3	Housekeeping	75,897	17,977		93,874		93,874		93,874			3
4	Laundry	44,814	13,849	468	59,131		59,131		59,131			4
5	Heat and Other Utilities			78,910	78,910		78,910		78,910			5
6	Maintenance	67,023	51,858	22,181	141,062		141,062	357	141,419			6
7	Other (specify):*											7
8	**TOTAL General Services**	316,640	232,075	107,426	656,141		656,141	357	656,498			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,129,457	43,782	108,165	1,281,404		1,281,404		1,281,404			10
10a	Therapy	65,920	2,428	4,286	72,634		72,634	(11,043)	61,591			10a
11	Activities	144,931	4,329	2,020	151,280		151,280		151,280			11
12	Social Services	36,650	197	2,016	38,863		38,863		38,863			12
13	Nurse Aide Training											13
14	Program Transportation	14,232			14,232		14,232		14,232			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,391,190	50,736	122,487	1,564,413		1,564,413	(11,043)	1,553,370			16
	C. General Administration											
17	Administrative	58,011			58,011		58,011		58,011			17
18	Directors Fees											18
19	Professional Services			14,964	14,964		14,964	11,889	26,853			19
20	Dues, Fees, Subscriptions & Promotions			5,659	5,659		5,659	224	5,883			20
21	Clerical & General Office Expenses	101,491	7,563	99,930	208,984		208,984	16,426	225,410			21
22	Employee Benefits & Payroll Taxes			296,563	296,563		296,563		296,563			22
23	Inservice Training & Education			4,459	4,459		4,459		4,459			23
24	Travel and Seminar			18,685	18,685		18,685	2,042	20,727			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,304	72,304		72,304	1,293	73,597			26
27	Other (specify):*											27
28	**TOTAL General Administration**	159,502	7,563	512,564	679,629		679,629	31,874	711,503			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,867,332	290,374	742,477	2,900,183		2,900,183	21,188	2,921,371			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number DIXON HEALTH CARE CENTER #0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			(23,619)	(23,619)		(23,619)	102,188	78,569			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			189,923	189,923		189,923	31,942	221,865			32
33	Real Estate Taxes			48,770	48,770		48,770		48,770			33
34	Rent-Facility & Grounds							46,179	46,179			34
35	Rent-Equipment & Vehicles			11,409	11,409		11,409		11,409			35
36	Other (specify):*											36
37	**TOTAL Ownership**			226,483	226,483		226,483	180,309	406,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,088	10,054	33,142		33,142		33,142			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,390	60,390		60,390		60,390			42
43	Other (specify):*							53,110	53,110			43
44	**TOTAL Special Cost Centers**		23,088	70,444	93,532		93,532	53,110	146,642			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,867,332	313,462	1,039,404	3,220,198		3,220,198	254,607	3,474,805			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,495)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,609)	21		24
25	Fund Raising, Advertising and Promotional	(7)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	73,494			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 37,383		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	213,729		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 213,729		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 251,112		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
DIXON HEALTH CARE CENTER
ID# 0040865
Report Period Beginning: 1/1/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Tax	$ (1,372)	21	1
2	Memorium/Benevolence Expense	(719)	21	2
3	Misc Receipts	(589)	21	3
4	Personal Purchases - Misc.	(5,117)	21	4
5	Depreciation Reconciliation	53,784	30	5
6	FAS 121*	48,404	30	6
7	Therapy adjustment	(11,043)	10a	7
8	Marketing Director Wages	(6,359)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16	* The provider re-valued the historical cost of its			16
17	assets. This adjustment is required to report			17
18	the historical cost of the assets in consistency			18
19	with prior years.			19
20				20
21				21
22				22
23				23
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78				78
79				79
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	76,989		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	357	0	0	0	0	0	0	0	0	0	357	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	357	0	0	0	0	0	0	0	0	0	357	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	(11,043)	0	0	0	0	0	0	0	0	0	0	(11,043)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(11,043)	0	0	0	0	0	0	0	0	0	0	(11,043)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,889	0	0	0	0	0	0	0	0	0	11,889	19
20	Fees, Subscriptions & Promotions	0	224	0	0	0	0	0	0	0	0	0	224	20
21	Clerical & General Office Expenses	(50,267)	66,693	0	0	0	0	0	0	0	0	0	16,426	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,042	0	0	0	0	0	0	0	0	0	2,042	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,293	0	0	0	0	0	0	0	0	0	1,293	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(50,267)	82,141	0	0	0	0	0	0	0	0	0	31,874	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(61,310)	82,498	0	0	0	0	0	0	0	0	0	21,188	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	**102,188**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**102,188**	30
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	31
32	Interest	**0**	**31,942**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31,942**	32
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	33
34	Rent-Facility & Grounds	**0**	**46,179**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**46,179**	34
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	35
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	36
37	**TOTAL Ownership**	**102,188**	**78,121**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**180,309**	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	38
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	39
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	40
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	41
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	42
43	Other (specify):*	**0**	**53,110**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**53,110**	43
44	**TOTAL Special Cost Centers**	**0**	**53,110**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**53,110**	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**40,878**	**213,729**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**254,607**	45

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Post Acute Network		$ 0	$	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network		357	357	2
3	V	19	Professional Services		Mariner Post Acute Network		11,889	11,889	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network		224	224	4
5	V	21	Clerical and General Office Expense		Mariner Post Acute Network		66,693	66,693	5
6	V	24	Travel and Seminar		Mariner Post Acute Network		2,042	2,042	6
7	V	26	Insurance Premium		Mariner Post Acute Network		1,293	1,293	7
8	V	32	Interest Expense		Mariner Post Acute Network		31,942	31,942	8
9	V	34	Rental & Leasing		Mariner Post Acute Network		46,179	46,179	9
10	V	43	Other Expenses		Mariner Post Acute Network		53,110	53,110	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 213,729	$ * 213,729	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Post Acute Network
Street Address: One Ravinia Dr, Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: (770) 379-8203
Fax Number: (770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	FACILITY COSTS			$ 212,153	$		$ 0	1
2	6	Repairs and Maintenance	FACILITY COSTS			1,115,193			357	2
3	19	Professional Services	FACILITY COSTS			19,156,199			11,889	3
4	20	Fees, Subscriptions, Promotions	FACILITY COSTS			352,775			224	4
5	21	Clerical and General Office Exper	FACILITY COSTS			51,126,150			66,693	5
6	24	Travel and Seminar	FACILITY COSTS			5,661,045			2,042	6
7	26	Insurance Premium	FACILITY COSTS			9,082,939			1,293	7
8	32	Interest Expense	FACILITY COSTS			31,744,386			31,942	8
9	34	Rental & Leasing	FACILITY COSTS			60,829,914			46,179	9
10	43	Other Expenses	FACILITY COSTS			8,511,848			53,110	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 187,792,602	$		$ 213,729	25

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Allocation										31,942	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 31,942	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 31,942	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	44,583	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	64,801	2
3. Under or (over) accrual (line 2 minus line 1).	$	20,218	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	28,552	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	48,770	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	41,914	8
	1996	42,404	9
	1997	46,169	10
	1998	47,121	11
	1999	44,583	12

2000 REAL ESTATE ACCRUAL: $28,552

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,710 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		1993	1976	$ 1,100,000	$ 31,429	35	$ 31,429	$	$ 226,703	4
5			1993		185,306	9,266	20	9,266		105,218	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	PARKING LOT REPAIRS			1996	2,925	146	20	146		628	17
18	ARCHITECT-TRANSICARE UNIT			1996	548	27	20	27		129	18
19	DOOR AND FRAME			1996	2,215	111	20	111		479	19
20	TILE FLOORING			1996	7,000	350	20	350		1,472	20
21	PAINTING			1996	3,115	156	20	156		647	21
22	DOORS AND FRAME			1996	2,215	111	20	111		457	22
23	INSTALL CEILING			1997	6,905	345	20	345		1,420	23
24	LAUNDRY REPAIR			1996	3,314	166	20	166		740	24
25	FLOOR CERAMIC TILE			1997	5,334	267	20	267		1,067	25
26	PAINT BUILDING			1997	3,021	151	20	151		539	26
27	CARPET			1997	1,439	72	20	72		258	27
28	GUTTERS & WINDOWS			1997	2,932	147	20	147		489	28
29	WALLS AND FLOORING			1997	1,100	55	20	55		171	29
30	STOREFRONT CONSTRUCTION			1998	8,353	209	20	209		627	30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,335,722	$ 43,008		$ 43,008	$	$ 341,044	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CONCRETE FOUNDATION			1998	720	36	20	36		108	9
10	ROOF COVERING/GUTTERS			1998	16,491	412	20	412		1,236	10
11	DUMPSTER AREA			1998	500	25	20	25		75	11
12	HVAC			1998	8,395	420	20	420		1,260	12
13	SECURITY SYSTEM			1998	2,284	114	20	114		342	13
14	CURTAINS & DRAPES			1998	1,985	99	20	99		297	14
15	AT&T PHONE SYSTEM			1993	6,676	668	20	334	(334)	3,690	15
16	HVAC UNITS			1994	1,787	179	20	89	(90)	901	16
17	HVAC UNITS			1994	2,680	268	20	134	(134)	1,353	17
18	HVAC COMPRESSOR			1994	2,747	275	20	137	(138)	1,287	18
19	A/C (5)			1995	4,964	496	20	248	(248)	1,968	19
20	A/C UNITS			1996	4,144	414	20	208	(206)	1,302	20
21	A/C (12)			1996	11,644	1,164	20	582	(582)	3,513	21
22	A/C UNIT			1996	1,057	106	20	53	(53)	303	22
23	A/C FAN MOTORS			1996	583	58	20	29	(29)	162	23
24	A/C - HEATING			1996	1,145	115	20	57	(58)	307	24
25	BASE HEATERS			1996	1,908	191	20	95	(96)	511	25
26	CURTAINS & DRAPES			1996	2,800	280	20	140	(140)	720	26
27	WATER STORAGE TANK			1996	1,114	111	20	56	(55)	270	27
28	CURTAINS & DRAPES			1997	10,592	1,059	20	530	(529)	2,527	28
29	DRAPE INSTALLATION			1997	820	82	20	41	(41)	173	29
30	ELEVATOR REPAIRS			1997	6,780	678	20	339	(339)	1,494	30
31	HOT WATER BOOSTER			1997	851	85	20	43	(42)	181	31
32	CUBICLE CURTAINS			1997	6,857	686	20	343	(343)	1,375	32
33	A/C UNITS (6)			1997	6,251	625	20	313	(312)	1,206	33
34	SECURITY SYSTEM			1997	2,284	228	20	114	(114)	364	34
35	CUBICLE CURTAINS			1997	4,952	495	20	248	(247)	825	35
36	TOTAL (lines 4 thru 35)				$ 113,011	$ 9,369		$ 5,239	$ (4,130)	$ 27,750	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	RECONCILING ADJUSTMENT TO WTB 1998			1998		14,956			(14,956)		9
10	LANDSCAPING			1998	1,198	30	20	30		90	10
11											11
12	4: RA/C QUIET ZONE 660			1999	1,280	256	5	256		384	12
13	ELECTRICAL WORK			1999	180	9	20	9		13	13
14	PLUMBING - WATER HEATER			1999	666	67	10	67		95	14
15	1: LOCHINVAR COPPER -			1999	4,366	437	10	437		619	15
16	PARTIAL ELEVATOR DOOR			1999	8,024	401	20	401		668	16
17											17
18	NURSE CALL SYSTEM			2000	1,986	215	10	215		215	18
19	INSTALL CHARGE, NURSE CALL SYSTEM			2000	1,415	118	10	118		118	19
20	NURSE CALL, SECOND INSTALL FEE			2000	2,000	117	10	117		117	20
21	2:RETROAIRE CHASSIS, DINING RM			2000	2,458	287	5	287		287	21
22	INSTALL 4" STEEL FIRE LINE			2000	1,132	26	25	26		26	22
23	FIRE ALARM PANEL INSTLD			2000	919	46	10	46		46	23
24	RPLC 4" GAS MAIN, LABOR ONLY			2000	662	15	25	15		15	24
25	RPLC 4" GAS MAIN			2000	802	19	25	19		19	25
26	CORE, GRADE SWAIL, WATER DRAINS			2000	3,405	114	15	114		114	26
27	BLDG GROUNDS REINFORCED, DRAINA			2000	3,900	130	15	130		130	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 34,393	$ 17,243		$ 2,287	$ (14,956)	$ 2,956	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 275,166	$ 27,290	$ 27,290	$		$ 189,939	37
38	Current Year Purchases	13,461	745	745			745	38
39	Fully Depreciated Assets	45,400					45,400	39
40								40
41	TOTALS	$ 334,027	$ 28,035	$ 28,035	$		$ 236,084	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,817,153	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 97,655	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 78,569	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (19,086)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 607,834	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	OVERHEAD ALLOCATION - 1996	$ 4,649	$ 232	$ 959	52
53	OVERHEAD ALLOCATION - 1997	2,976	149	506	53
54					54
55					55
56					56
57	TOTALS	$ 7,625	$ 381	$ 1,465	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,409 Description: Vehicle: $10,972; Non-Medical Equipment $437
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Medical Transportation	1999 FORD Econoline Wa	$ 915.00	$ 10,972	17
18					18
19					19
20					20
21	TOTAL		$ 915.00	$ 10,972	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 424	$	$ 424
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		1,600		1,600
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 2,024	$	$ 2,024
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,024			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	5
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	1
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-1	98 hrs	$ 2,907		$	$	98	$ 2,907	1
2	Licensed Speech and Language Development Therapist	10A-1,3	21 hrs	322		994		21	1,316	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1,3	hrs	1,742		2,818	2,428		6,988	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			9,900	23,088		32,988	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Audiologist	10A-3				154			154	13
14	TOTAL			$ 4,971		$ 13,866	$ 25,516	119	$ 44,353	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number DIXON HEALTH CARE CENTER **#** 0040865 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 580	$	1
2	Cash-Patient Deposits	38,642		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	61,315		3
4	Supply Inventory (priced at)	20,565		4
5	Short-Term Investments	220		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,408		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 122,730	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	101,386		13
14	Buildings, at Historical Cost	143,438		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	88,823		16
17	Accumulated Depreciation (book methods)	(191,738)		17
18	Deferred Charges	54,000		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 195,909	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 318,639	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 469,236	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	136,782		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,883		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,552		32
33	Accrued Interest Payable	(5,516)		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule 17.1	235,205		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 881,142	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule 17.1	4,435,003		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,435,003	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,316,145	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,997,506)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 318,639	$	48

***(See instructions.)**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,534,535)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,534,535)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(462,971)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (462,971)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,997,506)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,480,921	1
2	Discounts and Allowances for all Levels	(897,721)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,583,200	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	109,193	6
7	Oxygen	9,418	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 118,611	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,495	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	37,880	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,334	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 49,709	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine	589	28
28a	Miscellaneous Receipts -See page 19.1	5,117	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,706	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,757,226	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	656,143	31
32	Health Care	1,564,412	32
33	General Administration	679,627	33
	B. Capital Expense		
34	Ownership	226,483	34
	C. Ancillary Expense		
35	Special Cost Centers	33,142	35
36	Provider Participation Fee	60,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,220,197	40
41	**Income before Income Taxes (line 30 minus line 40)****	(462,971)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (462,971)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,003	2,118	$ 47,933	$ 22.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,763	19,845	347,782	17.52	3
4	Licensed Practical Nurses	12,079	12,775	189,430	14.83	4
5	Nurse Aides & Orderlies	51,945	54,940	522,026	9.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	118	125	5,246	41.97	7
8	Rehab/Therapy Aides	3,039	3,084	63,081	20.45	8
9	Activity Director	1,025	1,084	13,512	12.46	9
10	Activity Assistants	14,623	15,466	130,837	8.46	10
11	Social Service Workers	3,719	3,934	35,583	9.04	11
12	Dietician					12
13	Food Service Supervisor	2,003	2,118	28,246	13.34	13
14	Head Cook	6,205	6,563	53,500	8.15	14
15	Cook Helpers/Assistants	6,720	7,108	46,239	6.51	15
16	Dishwashers					16
17	Maintenance Workers	6,835	7,230	65,732	9.09	17
18	Housekeepers	10,282	10,875	78,143	7.19	18
19	Laundry	7,089	7,498	45,721	6.10	19
20	Administrator	2,099	2,220	64,478	29.04	20
21	Assistant Administrator					21
22	Other Administrative	957	1,012	12,096	11.95	22
23	Office Manager					23
24	Clerical	6,967	7,369	85,526	11.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,187	1,255	10,489	8.36	31
32	Other Health Care(specify)					32
33	Other(specify) Driver/Marketing	1,980	2,094	21,732	10.38	33
34	TOTAL (lines 1 - 33)	159,638	168,713	$ 1,867,332 *	$ 11.07	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 5,810	1-3	35
36	Medical Director	104	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	2,020	11-3	44
45	Social Service Consultant	96	2,016	11-12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	392	$ 15,846		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	73	$ 2,632	10-3	50
51	Licensed Practical Nurses	66	2,095	10-3	51
52	Nurse Aides	4,568	89,011	10-3	52
53	TOTAL (lines 50 - 52)	4,707	$ 93,738		53

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wayne Brown	Administrator		$ 16,819
Lori Cain			8,220
Vicky Debord			32,972
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,011

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
See detail	Legal Fees	$ 14,964
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 14,964

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,520
Unemployment Compensation Insurance	23,428
FICA Taxes	135,984
Employee Health Insurance	91,869
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other employee benefits	7,762
TOTAL (agree to Schedule V, line 22, col.8)	$ 296,563

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	5,459
Home Office Allocation	224
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,883

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	18,685
Home Office Allocation	2,042
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,727

**See instructions.

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DIXON HEALTH CARE CENTER # 0040865 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Healthcare Association $4,860

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 60,390
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? No Indicate the amount. $ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.